Alcohol: When One Drink Just Isn't Enough

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Agenda

- Why Do We Care?
- Screening, Classifying, Intervening
- Alcohol Withdrawal Syndrome
- Treating Alcohol Withdrawal
- Drugs to Prevent Recidivism

Why Do We Care?

- Lifetime prevalence 10 - 15%
- The “family” impact 43%
- Primary care patients 20%
- Medical and economic impact

Screening Recommendations

Regular screening of adolescent patients

- U.S. Preventive Services Task Force
- American Academy of Family Physicians
- American Medical Association
- American Academy of Pediatrics
- American College of Obstetrics and Gynecology

How are we doing?

- National Center on Addiction and Substance Abuse - 648 physicians across the country
  - 94% of PCP's, 41% of Pediatricians miss the diagnosis
  - 58% don't discuss with patients
- Why?

Barriers to Effective Screening

- Screening
  - 20% felt trained/prepared to make diagnosis
  - No standardized approach to screening
  - Time constraints/Lack of compensation
- Traditional classification
  - No drinking problem
  - Alcoholic
- 4% felt treatment effective

CAGE

- Have you ever felt the need to **cut** down?
- Has anyone **annoyed** you by criticizing your drinking?
- Have you felt **guilty** because of something you've done while drinking?
- **Eye-opener** or “steady my nerves” drink?

CAGE

- Pro's
  - Short/quick
  - Finds problem drinker
- Con's
  - White males only
  - Misses at-risk drinker
  - Does not address old/active
  - Does not indicate quantity/frequency

A.U.D.I.T.

Alcohol Use Disorders Identification Test

- How often do you have a drink?
- How many drinks on a typical day when you drink?
- How often do you have 6 or more?
- How often during last year were you unable to stop once you started?

A.U.D.I.T.

Alcohol Use Disorders Identification Test

- How often during last year did you fail to do something because of drinking?
- How often during last year have you needed an eye opener?
- How often during last year did you feel guilty after drinking?

A.U.D.I.T.

Alcohol Use Disorders Identification Test

- How often have you not been able to remember what happened the night before from drinking?
- Have you or someone else been injured as a result of your drinking?
- Has someone suggested you cut down?

A.U.D.I.T.

Alcohol Use Disorders Identification Test

- Pro's
  - Sensitivity 70 - 92%
  - Specificity 73 - 94%
  - Developed over 6 countries, results consistent across gender/ethnic/race/age boundaries
- Con's
  - Too long (10 questions)

Recommended Questions

- CAGE
  - If no use, ask why
- How often do you drink?
- How many drinks when you drink?
- What's the most number of drinks at one time past 30 days?

Classification

- No use
- Low-risk drinking

  Men ≤ 2 drinks/day, Women/Elderly ≤ 1 drink/day

  AND - No risky use

  AND - No binges (4 or more drinks)
- At-risk drinking

  Men ≥ 14 drinks/week or ≥ 4 drinks/occasion

  Women/Elderly 7/3

  OR - Risky use

  OR - Family history

  AND - No current problems related to

Classification

- Problem drinking

  Adverse consequences related to alcohol use

  AND - No evidence of dependence

- Alcohol dependence

  Continued use in the face of adverse consequences

  Withdrawal/tolerance

  Impaired control

  Compulsion to drink

The Approach

Step 1: Screen

Do you drink?

YES

- CAGE
- Quantity
- Frequency

NO

- Reason

The Approach

Step 2: Classify

- No use
- Low-risk drinking
- At-risk drinking
- Problem drinking
- Alcohol dependence

The Approach

Step 3: Intervene

- Low risk drinking
  - Reinforce behavior
- At-risk drinking
  - PCP counseling on risks/Pt education
- Problem drinking
  - PCP counsels/educates on drinking and adverse consequences
  - +/- Referral
- Dependence
  - PCP as above
  - Referral

Alcohol Withdrawal Syndrome

- 3 distinct phases:
  - Autonomic Instability
  - Alcohol Withdrawal Seizures
  - Delirium Tremens
- Can be a continuum versus sporadic presentation
- Can be accomplished as inpatient or outpatient depending on severity and social circumstances

Autonomic Instability

- Starts soon - lasts 48-72 hours
- Clinical Manifestations:
  - Tremulousness - Irritability
  - Anorexia - Nausea
  - Tachycardia - Hypertension
  - Hallucinations
- Remember:
  - Quiet room - Well-lit room
  - Thiamine - MVI with folate
  - Healthy diet - Family and friends

Alcohol Withdrawal Seizures

- 12-72 hours after stopping/cutting back
- Generalized, tonic-clonic seizures lasting only a few minutes
- Exclude other causes of seizures
- No indication for neuroleptic therapy
- Remember patient safety

Delirium Tremens

- 72 to 96 hours after stopping/cutting back
- Usually resolves 3-5 days after starting
- Complicates 5-10% of withdrawals
- Mortality up to 15%
- Clinical Manifestations:
  - Tremulousness
  - Agitation
  - Disorientation
  - Hallucinations
  - Confusion
  - Fever
- Remember: Fluids and Electrolytes

Treating Withdrawal

- Inpatient versus Outpatient
- Benzodiazepines remain cornerstone
  - Generous therapeutic range
  - Short-acting: lorazepam
    - Peaks and valleys
    - Ideal for older patients/impaired drug clearance
  - Medium/Long-acting: diazepam/chlordiazepoxide
    - Long, slow tapers
    - Ideal for outpatient
  - Oxazepam
    - Severe hepatic dysfunction
- No efficacy:
  - MgSO4 - Neuroleptics
  - Clonidine - Anti-psychotics
  - Atenolol - Anti-emetics

Treatment Algorithms

- AWSI-Based Withdrawal
  - Example: Lorazepam 2 mg q 1-2 h AWSI > 4

Pro's	Con's
- Less medication used	- "Acceptable" seizure rate
- Shorter hospital stays	- Higher nurse involvement

- Scheduled-Dosing
  - Example: Chlordiazepoxide 100 mg q 6 h

Pro's	Con's
- Convenience	- Higher medication use
- Adaptable to outpatient	- Less nurse interaction

- Load and Taper
  - Example: Diazepam 10 mg q 2 h until asleep

Pro's	Con's
- Patient comfort	- Unnecessary medication use
- Physician easy	- Over sedation

Willingway Protocol

- Advantages versus Disadvantages

Advantages	Disadvantages
- Long, slow taper	- Inpatient only/long stay
- Little drug cross-reactivity	- Over sedation
- Multi-drug abuse patients	- Most unaware/uncomfortable

- Phenobarbital-scheduled dosing:
  - Days 1 and 2 – 60mg po q 6 h
  - Days 3 and 4 – 30 mg po q 6 h
  - Days 5 and 6 – 15 mg po q 6h
  - Day 7 – 15 mg po q 12 h
  - PRN: 120-240 mg IM or 60 mg po

Decreasing Recidivism

39 year-old white female – alcohol abuse disorder. S/P both inpatient/outpatient detoxification with rehab multiple times. Longest period of abstinence - 4 days. No improvement with ASAP or AA. Referred to PCM from psychology and psychiatry to assess drug therapy to decrease recidivism rate.

Decreasing Recidivism

- Behavioral Modification
  - The Gold Standard.
  - AA – focuses on abstinence as goal - ? Controversial.
  - Lifestyle changes. Key.
- Drug Therapy
  - Disulfiram (Antabuse)
  - Naltrexone (Revia)
  - Acamprosate (Campral)
  - Others

Disulfiram (Antabuse)

- 250 – 500 mg daily in divided dose
- Block EtOH metabolism – increase acetaldehyde
- Antabuse Reaction: Flushing, nausea, headache
- Negative reinforcement
- Contraindicated: heart disease
- Caution: diabetes, abnormal LFT's
- Mixed efficacy per EBM. Lack of data to support generalized use in PCM settings.
  - Role in day programs – observed compliance.
  - ? Combination with acamprosate and/or naltrexone.

Naltrexone (Revia)

- 50 mg once daily
- Opiate antagonist.
- Unknown mechanism of action: ? Decrease pleasure.
- Caution: GI side effects, elevated LFT's, concomitant use of opiod analgesics
- EBM: Mixed data. Initially appeared very good with decreased recidivism at 6 months. Follow-on data less encouraging.
  - NNT: 7-18 pending study (outcomes differ)
  - Multiple studies using primary care settings – not much different outcomes compared to behavioral science settings
  - Combination therapies with disulfiram and/or acamprosate

Acamprosate (Campral)

- Recent FDA approval – available in Europe for some time.
- 666 mg three times daily
- Unknown mechanism of action
- Limited safety concerns
  - Few drug-drug interactions
  - ? Increase suicide attempts
  - Diarrhea most common side effect
  - Teratogenic in animals
  - No evidence of abuse/dependence

Acamprosate (Campral)

- EBM
  - Kiritze-Topor, et al. Alcohol and Alcoholism. 2004; 29(6):520-7.
    - 422 patients tx'd by 1,100+ PCM's in France.
    - Measured: EtOH incidences over 1 year.
    - NNT: 7.1 to decrease incidences by one per year.
  - The Medical Letter. 2005; 47(1119):1-3.
    - 5 RCT's reviewed. Length ranged from 8 weeks to 12 months. Outcome measures – complete abstinence.
    - 1,721 total patients reviewed.
    - ARR ranged 1-26%. NNT: 100, 20, 12.8, 6.6, and 3.8.
    - Strongest Study: NNT 12.8 to keep one patient from drinking at 24 weeks.
- Extensive primary care studies – outcomes similar compared to use in behavioral science settings. Wide variety of outcome measures.

Conclusion

- Alcoholism and Alcohol Use Disorders deserve out attention.
- Screen and identify at risk patients.
- Multiple safe ways to detox patients.
- Use drug therapy when appropriate as adjuncts to behavioral therapy.

- BOTTOMLINE: Excellent role for PCM’s.